



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

THE METHODIST HOSPITAL  
PO BOX 1866  
FORT WORTH TX 76101

#### **DWC Claim #:**

**Injured Employee:**

**Date of Injury:**

**Employer Name:**

**Insurance Carrier #:**

#### **Respondent Name**

FACILITY INSURANCE CORP

#### **Carrier's Austin Representative Box**

#19

#### **MFDR Tracking Number**

M5-06-0366-01

#### **MFDR Date Received**

October 17, 2005

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary as stated on the Table of Disputed Services:** "Stop Loss Factor Applies"

**Amount in Dispute:** \$102,921.95

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary Dated November 3, 2005:** "The requestor asserts it is entitled to reimbursement in the amount of \$114,711.15, which is 75% of the total charges." "Using the per diem method, this five day surgical admission qualifies for \$5590.00 in reimbursement...Further; the Requestor is entitled to reimbursement for implantables based on the hospital's cost plus 10%."

**Responses Submitted by:** Flahive, Ogden & Latson

### **SUMMARY OF FINDINGS**

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 18 through 29, 2005	Inpatient Hospital Services	\$102,921.95	\$1,561.41

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### Explanation of Benefits

- W1 – payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital fee Guideline
- W1 – implantables reimbursed at COST + 10%
- W10 – No maximum allowable defined by fee guideline. Reimbursement based on insurance carrier fair and reasonable reimbursement methodology
- W4 – No additional reimbursement allowed after review of appeal/reconsideration
- W3 – additional payment made on appeal/reconsideration
- B15 – payment adjusted because this procedure/service is not paid separately
- 50 – these are non-covered services because this is not deemed a medical necessity by the payer
- W9 – unnecessary medical treatment based on peer review

#### Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

#### Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original Medical Dispute Resolution submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$152,948.20. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its original position statement asserts that "Stop Loss Factor Applies." In its position statement, the requestor presumes that it is entitled to the stop-loss method of payment. The Third Court of Appeals in its November 13, 2008 opinion concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to discuss and demonstrate the particulars of the admission in dispute that constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presumes that the stop-loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss and demonstrate the particulars of the admission in dispute that constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
4. For the reasons stated above, the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
- Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The respondent denied six Intensive Care Unit (ICU) days under 'W9 - unnecessary medical treatment based on a peer review.' These ICU days were disputed in accordance with 28 Texas Administrative Code §133.308. The IRO in this matter agreed with the carrier decision to deny the services based on medical necessity; therefore, these six ICU days cannot be considered for reimbursement. Consequently, there are 5 medical days eligible for reimbursement pursuant to §134.401(c)(3)(ii). The per diem rate of \$1,118 multiplied by the 5 allowable days, results in a total allowable amount of \$5,590.00.
  - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed \$992.00 for Tobramycin 1.2gm vial; \$260.00 for Suprane bottle; \$639.00 for Daptomycin 500mg vial; and \$545.00 for Moxifloxacin. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, reimbursement for these items cannot be recommended.
  - 28 Texas Administrative Code §134.401(c)(4)(A) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

Service code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
C1776	Imp knee nex gen femur lck	Nexgen knee lck femoral	1 @ \$3266.25	\$3266.25	\$3592.88
	Imp knee nex gen fem aug blk	Nexgen augment block distal only	2 @ \$ 601.25	\$1202.50	\$1322.75
	Implant knee stem extension	Nexgen straight stem ext	1 @ \$646.75	\$ 646.75	\$ 711.43
	Imp knee nex gen tib insert lc	Nexgen tibial augment block	1 @ \$601.25	\$ 601.25	\$ 661.38
	Imp knee nex gen tibial tray	Nexgen precoat stemmed tibial plate	1 @ \$1338.35	\$1338.35	\$1472.19
C1713	Imp anchor suture statak	No invoice provided	NA	NA	NA
TOTAL ALLOWABLE				\$7,760.61	

The division concludes that the total allowable for this admission is \$5,590.00 + \$7,760.61 for a total of \$13,350.61. The respondent issued payment in the amount of \$11,789.20. Based upon the documentation submitted, additional reimbursement in the amount of \$1,561.41 is recommended.

**Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of \$1,561.41 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	<u>October 17, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**